STATE OF DELAWARE
DEFERRED COMPENSATION PROGRAM

APPLICATION
FOR DISTRIBUTION DUE TO UNFORESEEABLE EMERGENCY WITHDRAWAL

The information contained in this application is of a confidential nature and is requested solely for review by the State of Delaware Deferred Compensation Council and its authorized representatives. It will not be used for any other purpose. The form is to be completed in ink.

SECTION 1

Participant Name: _____SSN: _____

Street Address: _____

City: _____State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

State of Delaware Agency: _____

Amount Currently Deferred Per Pay Period: $_____

Current Balance in 457: _____ in 401(a): _____ in 403(b): _____

SECTION 2

(Attach a separate sheet if more room is needed)

A. <u>Description of unforeseeable emergency (qualifying event)</u>:

_____
_____
_____
_____
_____

B. <u>Describe the resulting financial hardship</u>:

_____
_____
_____
_____
_____

SECTION 3

List of expenses directly related to the financial emergency and the Payee:

PAYEE	EMERGENCY SERVICES	AMOUNT
_____	_____	$ _____
_____	_____	$ _____
_____	_____	$ _____
_____	_____	$ _____
_____	_____	$ _____
	Total Amount Applied for	$ _____

SECTION 4

Financial Assets:	Current Value	
Cash	$ _____	
Checking/Savings Accounts	$ _____	
Stock, Bonds, Mutual Funds	$ _____	
401(k)/IRA Accounts	$ _____	
All Other Assets (list)		
_____	$ _____	
_____	$ _____	
_____	$ _____	
_____	$ _____	
Total Financial Assets		$ _____

SECTION 5

Current Monthly Income Computed from Payroll Advices

	Your Salary	Spouse's Salary	Other Income	Total
Gross Pay	$ _____	$ _____	$ _____	$ _____
Less:				
FWT	$ _____	$ _____	$ _____	$ _____
SWT	$ _____	$ _____	$ _____	$ _____
FICA	$ _____	$ _____	$ _____	$ _____
OASDI	$ _____	$ _____	$ _____	$ _____
Local Tax	$ _____	$ _____	$ _____	$ _____
Other Before tax	$ _____	$ _____	$ _____	$ _____
Other After tax	$ _____	$ _____	$ _____	$ _____
Net Income	$ _____	$ _____	$ _____	$ _____

SECTION 6

Monthly Living Expenses: Provide documentation to support these expenses. If deduction is included on payroll advice, as for health insurance premium, no additional documentation is required.

		Verification/Documentation
Home mortgage expense/Rent	**$** _____	_____
Basic Utilities (electric, gas, water, telephone within last two months)	**$** _____	_____
Other Utilities(cable, cell, internet, home security)	**$** _____	_____
Food and Clothing Allowance	**$** _____	_____
Car Payments	**$** _____	_____
Other Transportation Expenses (gas, vehicle insurance, parking, public transit)	**$** _____	_____
Credit Card Payments(combined total, minimum required payments)	**$** _____	_____
College Expenses of Dependents	**$** _____	_____
Insurance Premiums (home or renters, life, health)	**$** _____	_____
Child Support	**$** _____	_____
Other (list) _____	**$** _____	_____
_____	**$** _____	_____

TOTAL Monthly Living Expense **$** _____

TAX WITHHOLDING – Please specify your current federal and state tax rates. If nothing is specified, no taxes will be withheld on distributions made.

Please withhold ____% for Federal Tax.
Please withhold State Tax _____, do <u>not</u> withhold State Tax _____.

I HEREBY CERTIFY THAT THE STATEMENTS AND FIGURES SHOWN ON THIS UNFORESEEABLE EMERGENCY WITHDRAWAL APPLICATION AND THE ATTACHMENTS THERETO ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE READ AND UNDERSTAND THIS APPLICATION. I UNDERSTAND THAT THIS APPLICATION WILL BE RETAINED BY THE PROGRAM ADMINISTRATOR AS PART OF MY PROGRAM RECORDS WHETHER OR NOT IT IS APPROVED. I HEREBY AUTHORIZE THE PROGRAM ADMINISTRATOR TO CONTACT ANY OF THE THIRD PARTIES REFERENCED IN THIS APPLICATION OR THE ATTACHMENTS THERETO IN ORDER TO VERIFY AND/OR SUPPLEMENT INFORMATION SUPPLIED BY ME.

SIGNATURE OF APPLICANT: _____ DATE: _____